NC DMA Pharmacy Request for Prior Approval
Sedative Hypnotics

Recipient Information **DMA-0022**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ Other:_____

Clinical Information

Request for Non-Preferred Drug:

1. ☐ Failed two preferred drug(s). If only one preferred drug is available, then failed one preferred drug.
List preferred drugs failed: _____
1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
_____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. ☐ Age specific indications. Please give patient age and explain: _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Criteria for exceeding quantity limit: (check all that apply)

7. Does patient have a diagnosis of chronic primary insomnia lasting one month or longer? ☐ Yes ☐ No
8. Has the patient received information on good sleep hygiene? ☐ Yes ☐ No
9. Does patient have a diagnosis of chronic secondary or co-morbid insomnia lasting one month or longer and has been evaluated for and is being actively treated for one of the following conditions? ☐ Yes ☐ No
If item 3 was checked "yes," then please check appropriate condition:
a. ☐ an underlying psychiatric illness associated with insomnia b. ☐ an underlying medical illness associated with insomnia (e.g. chronic pain associated with cancer, inflammatory arthritis, etc.) c. ☐ a sleep disorder such as restless legs syndrome, sleep-related breathing disorder, sleep-related movement disorder or circadian rhythm disorder
10. Is patient being discontinued from a sedative hypnotic and tapering is required to prevent symptoms of withdrawal? ☐ Yes ☐ No
11. Is patient being actively assessed for a diagnosis of chronic primary or secondary/co-morbid insomnia?
☐ Yes ☐ No (Do not check "yes" if answer to #1 is "yes.")

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp V.01